

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003902</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/10/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT PRESTWICK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>182 S CR 550 E</b> <b>AVON, IN 46123</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00143971.</p> <p>Complaint IN00143971 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: April 10, 2014</p> <p>Facility number: 0003902 Provider number: 0003902 AIM number: N/A</p> <p>Survey team: Connie Landman RN-TC Megan Burgess RN</p> <p>Census bed type: Residential: 128 Total: 128</p> <p>Census payor type: Other: 128 Total: 128</p> <p>Sample: 3</p> <p>Hearth at Prestwick was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00143971.</p> <p>Quality Review 04/11/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE